AMERICAN HEALTH GROUP

Provider Application

If you are a physician and would like to be in American Health Group's provider network, please follow the steps below.

1. To receive a participation packet and application, print out the form at the bottom of this page with all information requested.

2. Mail or fax to: American Health Group
Managed Care Department
P.O. Box 1500
Maumee, OH 43537
Fax: 419.891.1280

3. If you have any questions, please call our Customer Service Department at 419.891.1212.

American Health Group

Provider Application Form

Office Contact Name:		
Provider's First Name:		
Provider's Last Name:		
Office Address:		
City:	**State:**	**Zip:**
Phone:		**Degree: (MD, DO, etc.)**
Specialty:		
Provider's Tax ID:		
Provider's Signature		

Mail To:

American Health Group
Attn: Managed Care Department
P.O. Box 1500
Maumee, OH 43537

Fax To:

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